Ebola rages through the Congo

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Four weeks after being declared a public health emergency of international concern (PHEIC), the Bundibugyo Ebola outbreak in central Africa is already three times larger than any previous Ebola epidemic at the same stage. According to a June 18 briefing by Africa Centres for Disease Control and Prevention epidemiologist Dr. Wessam Mankoula, reported by *Health Policy Watch* in "Ebola Outbreak is Three Times Bigger Than Previous Outbreaks at Four Weeks," the 2014 to 2016 West Africa epidemic registered only 242 cases four weeks after its emergency declaration, though it ultimately became the largest in history with roughly 28,600 infected. The 2000 Uganda outbreak had reached only 281 cases at this point. The current epidemic has surged to an unprecedented 894 confirmed cases.

These 894 infections span 32 health zones across the eastern Democratic Republic of the Congo (DRC) and Uganda, with the death toll surpassing 200. The DRC outbreak presently carries a case fatality rate of roughly 23 percent, and Ituri Province accounts for more than 90 percent of cases. Medical infrastructure is overwhelmed: nine Ebola treatment centers in Ituri are operating at over 90 percent capacity. Uganda has contained its spread to 19 cases and two deaths. The outbreak shows no sign of slowing, with a 38 percent week-over-week jump in cases.

While some local health zones report declining suspected case counts, this is no sign of containment. A drop in suspected cases reflects the breakdown of disease surveillance and diagnostic testing, not the retreat of the virus. The rate of confirmed cases continues to climb. The outbreak was only officially confirmed on May 15, weeks after transmission had begun, because medical personnel were not equipped to test for the Bundibugyo strain, allowing the virus to spread undetected.

Returning from his second visit to the northeastern epicenter, World Health Organization Director-General Tedros Adhanom Ghebreyesus warned that the virus is moving much faster than the global response. Contact tracing has collapsed. Against an expected 17,000 to 35,000 contacts, health workers have traced only about 4,000 individuals, less than 15 percent of the necessary targets.

The pathogen is the Bundibugyo strain of the Ebola virus, which historically carries a 30-50 percent fatality rate and has no approved vaccine or specific treatment. Yet early, aggressive supportive care saves lives. The soaring death toll measures the absence of medical infrastructure and the depth of imperialist neglect.

Mass displacement is the primary accelerant. According to the United Nations humanitarian office, nearly a million people have been displaced by years of armed conflict in Ituri Province, forced to navigate dense forests, poor roads and remote villages that can take days to reach. Tracing is defeated further by the region's mineral economy, with thousands of artisanal miners moving constantly among remote sites, a high-velocity movement of labor driven by extreme poverty and the demands of global supply chains and inextricably linked to the imperialist extraction of Congo's wealth. The virus has now reached locations like the Kpangba displacement camp, which traps roughly 30,000 people who have fled inter-ethnic violence. Conditions are catastrophic, with hundreds sometimes sharing a single toilet and open defecation common. Caitlin Brady, country director for the Danish Refugee Council, warned that the virus will spread extremely quickly in such cramped conditions, sparking mass panic and flight.

The major capitalist powers have engineered a profound biological vulnerability among the region's youth. Dr. Douglas Noble, a UNICEF global incident manager for Ebola, warned that as the outbreak shifts toward household transmission, children will increasingly bear the brunt. In Ituri Province, more than half of all children under five are chronically malnourished, and more than one in five are "zero dose" children who have never received a single routine vaccination. With immune systems compromised by systemic deprivation, children face the highest fatality rates.

The international response is colliding with intense and justified community mistrust. During his visit, residents bluntly told Tedros that foreign powers intervene only to keep the virus from reaching Western borders, not to save African lives. "It's not because you want to save our lives. It's not for us, it's for you," they told the WHO chief. This is a correct political analysis. Tedros was forced to acknowledge that the population views Ebola as a "lesser evil" compared to the daily horrors they face, conceding that the numbers dying from armed conflict, malaria and starvation dwarf those dying from Ebola.

This alienation recently erupted in the town of Rwampara, where residents set fire to an Ebola treatment center after authorities blocked them from retrieving the body of a local Catholic preacher, Sylvestre Atama, for traditional funeral rites. The danger of such funerals is well documented. A 2017 study in *PLOS Neglected Tropical Diseases* by Amanda Tiffany and colleagues found that a single unsafe burial generated an average of 2.58 secondary infections. The resistance to safe burial protocols is not ignorance. Communities facing constant violence and deprivation see their everyday health and economic crises ignored by the world, yet watch authorities grow intrusive and militarized the moment a virus threatens to disrupt global markets.

The public pronouncements of global leaders portray a

coordinated international effort, but the financial reality exposes a deliberate deception. More than $910 million was pledged to combat the outbreak, including $80 million from African member states mobilized at a June 16 emergency meeting of the African Union convened by Burundian President Evariste Ndayishimiye. Yet less than $90 million, under 10 percent of the total, has reached responders. The $518 million joint continental response plan remains effectively unfunded, despite the African Union's resolution to disburse it within four weeks. The Africa CDC needs 540 personnel on the ground but has deployed only 84. Director-General Dr. Jean Kaseya was reduced to pleading with donors that every pledge must translate into financing, medical supplies and personnel reaching affected communities.

The structural cause of this collapse is the deliberate dismantling of global public health infrastructure by the Trump administration. A June 2026 interim staff analysis by the House Committee on Oversight and Government Reform, "People Are Already Dying, and More Will Die," lays this out. The congressional report cites a study in *The Lancet*, "Evaluating the impact of two decades of USAID interventions and projecting the effects of defunding on mortality up to 2030" by Daniella Medeiros Cavalcanti and colleagues, which estimated that the dismantling of the US Agency for International Development in July 2025 has already caused more than 600,000 preventable deaths, the vast majority of them children.

The loss of this public health scaffolding turned the emergence of the Bundibugyo virus into a catastrophe. Dr. Phuong Pham of the Harvard T.H. Chan School of Public Health detailed exactly what was destroyed. During the 2018 DRC Ebola outbreak, USAID coordinated the training of thousands of local healthcare workers, conducted massive contact tracing, bolstered laboratory capacity and facilitated the vaccination of more than 300,000 people. The contrast with today reveals the consequences of the cuts. The surveillance networks that would have caught this outbreak early were gone, and local laboratories could not test for the Bundibugyo strain, allowing the virus to spread undetected for weeks. The resulting brain drain of international and local experts destroyed the community trust on which any response or future vaccine rollout depends. Abandoning long-term preparedness for an emergency scramble ensures mass casualties. The scale of this outbreak was a policy choice.

The US response to this manufactured crisis has been a quantifiable pittance. In mid-May, the State Department pledged a mere $23 million in emergency funding for surveillance and 50 screening and treatment clinics, followed by a $20 million pledge for preparedness in neighboring countries. That $23 million figure should be held in mind against the private fortunes detailed below. To obscure the austerity regime's impact, US officials have provided ideological cover. Appearing on the *NewsNation* program, Acting CDC Director Dr. Jay Bhattacharya flatly denied that the foreign aid cuts harmed the Ebola response, claiming he had seen no evidence the defunding hindered containment.

Against this stands the staggering accumulation of private wealth. The recent SpaceX initial public offering added more than $180 billion to the personal fortune of Elon Musk in a matter of days. Two ratios capture the reality of global capitalism. That single-week windfall is 7,826 times the entire $23 million US emergency Ebola response, and roughly 400 times the approximately $450 million global funding shortfall for the continental response plan.

Musk has become the world's first trillionaire. SpaceX began trading on the Nasdaq under the ticker SPCX the week of June 12, priced at $135 and opening near $150, pushing the company to a valuation approaching $1.8 trillion in the largest initial public offering in history. This propelled Musk's combined net worth to between $1.05 trillion and $1.14 trillion. He now exceeds the gross domestic product of entire nations, such as Taiwan, Ireland or Sweden, and is worth more than the next five richest billionaires combined.

Alongside this oligarchy sits the rapacious war machine. The Stockholm International Peace Research Institute found that global military spending surged to a record $2.887 trillion in 2025, the 11th straight year of growth. The United States alone spent $954 billion, and the Trump administration has requested a $1.5 trillion defense budget for 2027. Set the $2.887 trillion spent globally on the machinery of death against the under $90 million delivered to fight Ebola in central Africa, and the true priorities of the capitalist system stand exposed.

The material resources to build comprehensive disease surveillance, advanced diagnostic labs, and robust community health networks demonstrably exist, as does the scientific capacity to develop and deliver a vaccine for the Bundibugyo strain. But these life-sustaining resources are monopolized by a criminal financial oligarchy that prioritizes the accumulation of private wealth and great-power war over the survival of the international working class. Even Dr. Phuong Pham, who is no socialist, concluded that the scale of this outbreak was a preventable consequence of abandoning long-term preparedness. The system has the cure for Ituri's dead, and it has chosen not to pay for it.